# **Endometriosis** Enrollment Form

## PATIENT INFORMATION

Patient Name: ______________________________________________
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: ______________________________________________
City: ____________________ State: ________ Zip: _______________

Phone: ( _____ ) - _____ - ________
Email: ______________________________________________
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

## PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: ______________________ ID#: ______________________ Group #: ______________ RxBIN: ____________ RxPCN: ____________

## PRESCRIBER INFORMATION

Prescriber Name: ______________________________________________
Address: ______________________________________________
City: ____________________ State: ________ Zip: _______________
Contact: _______________ Clinic/Hospital Affiliation: _______________

Phone: ( _____ ) - _____ - ________ Fax: ( _____ ) - _____ - ________
License #: ______________________________________________
NPI #: ______________________________________________
Medicaid Provider #: ______________________________________________

EMRX-20-01

## CLINICAL CONSIDERATIONS

Diagnosis:
☐ N80.0 Endometriosis of uterus
☐ N80.1 Endometriosis of ovary
☐ N80.2 Endometriosis of fallopian tube
☐ N80.8 Other endometriosis
☐ N80.9 Endometriosis, unspecified
☐ Other: ______________________

History of therapies tried/failed (please include dates):

Is patient new to therapy?: ☐ Yes ☐ No
Diagnosis Date: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐**Lupron Depot®** (leuprolide acetate for depot suspension) | ☐ 3.75 mg kit (1-month) | ☐ Administer intramuscularly once a month | 1-kit | |
| | ☐ 11.25 mg kit (3-month) | ☐ Administer intramuscularly once every three months | 1-kit | |
| ☐**Lupaneta Pack™** (leuprolide acetate for depot suspension and norethindrone acetate tablets) | ☐ 3.75 mg kit (1-month) *Includes norethindrone acetate 5 mg tablets (qty: 30) | ☐ Administer intramuscularly once a month (in addition to norethindrone acetate – 1 tablet by mouth daily) | 1-kit | |
| | ☐ 11.25 mg kit (3-month) *Includes norethindrone acetate 5 mg tablets (qty: 90) | ☐ Administer intramuscularly once every three months (in addition to norethindrone acetate – 1 tablet by mouth daily) | 1-kit | |
| ☐**Orilissa™** (elagolix) | ☐ 150 mg tablet | ☐ Take 1 tablet by mouth once daily | | |
| | ☐ 200 mg tablet | ☐ Take 1 tablet by mouth twice daily | | |

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

**Prescriber's Signature:** ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

## SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

**PHONE**: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherxrare.com**

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